



BUREAU TALK

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www.dhss.mo.gov/HomeCare



STAFF CHANGES

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We, the Bureau of Home Care & Rehabilitative Standards, are pleased to announce we have no staff changes! However, effective November 27, 2006, Jane Drummond was named the new Director of the Department of Health & Senior Services. Jane previously was employed in the Department's legal council and currently comes back to our department from the Governor's office. Please join our Bureau in welcoming Jane to the Department!

There have also been a few changes at the CMS Regional and Central Offices. Pete Gruber will be retiring 6/1/07 from CMS Regional Office. MaryAlice Futrell has already retired. Diana Moran has now taken

over MaryAlice's duties. At CMS Central Office in Baltimore, Mavis Connolly has retired. Pat Sevast has taken over for Home Health and Kim Roche has taken on Hospice duties.



Bureau of Home Care and Rehabilitative Standards Staff

CCN

Centers for Medicare & Medicaid Services

Following the implementation of the National Provider Identifier (NPI), the Medicare/Medicaid Provider Number will continue to be issued to certified providers/suppliers and used on all Survey and Certification, and patient assessment transactions. In order to distinguish its role from

that of the NPI, the Medicare/Medicaid Provider Number has been renamed the Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN). By law, the NPI will become the only acceptable provider identifier on Health Insurance Portability and Accountabi-

lity Act of 1996 (HIPAA) Standard Transactions (i.e., claims, remittance advice, eligibility inquiries, prior authorization and referral, and claims status). However, post NPI implementation, the Medicare/Medicaid Provider Number will continue to be issued to certified providers/suppliers

CCN Continued

and used to verify Medicare/Medicaid certification on all survey and certification and resident/patient assessment transactions.

Effective immediately, 'CCN' will

replace the term 'Medicare/Medicaid Provider Number' in survey and certification, assessment-related activities, and communications. When the NPI is called for on any form or transaction, it should be provided, if available. When

the Medicare/Medicaid Provider Number (also known as the Online Survey, Certification, and Reporting (OSCAR) Number; Medicare Identification Number; or provider number) is requested, the CCN should be provided.

HOT LINE

Effective November 1, 2006, the new hotline number, 1-800-392-0210, went into effect. The old hotline number is no longer in service. Effective immediately, any agency who does not have the

Patient Bill of Rights updated with the new number and the new operational hours of 24 hours/day, 7 days/week, will be cited as not meeting the conditions of participation.



HOME CARE WEBSITE

Expect to see changes to the Bureau's web site in the coming months! The Bureau policy committee has worked very hard over the last year to update all the policies that pertain to home health, hospice, OPT, and CORF. In the process

of updating the policy manual this committee has also updated many components of the Bureau's website. Enhancements have been made to provide better resources for providers. Some of the enhancements have already been

posted. We are hopeful that within the next couple of months the entire website will be fully updated with all the new information. We think you will find the website much more user friendly!

AGENCY CHANGES

This is your friendly reminder that the Bureau **must** be notified of any changes that occur within your agency! We cannot say it enough that we need to know of any of the following changes:

- Address changes
- Changes in Administration and/or Supervising R.N.
- Adding or deleting services
- CHOWS (Change in Ownership)

Also, remember email is your source of information. Please keep the Bureau updated with current email addresses! This is the only way your agency will be notified of such things as:

- Disaster alerts
- Annual reports
- Bureau Talks
- Updates on Policies and Procedures

FAXES

The Bureau has recently been notified that we will soon be moving to a "paperless" system. All documents received will be scanned and the originals destroyed. Because faxed copies do not scan well, effective May 1, 2007, the Bureau will no longer accept faxed information. We encourage agencies to use our overnight address which is 930 Wildwood, Jefferson City, Missouri 65109, Attention Home Care.

No patient information can be sent by fax. If your agency has an

emergency request for temporary extension of your coverage area you will need to phone the Bureau at 573-751-6336 with the patient's name, physician's name, diagnosis, approximate length of time your agency plans to service the patient, and how far over the boundary the patient lives.



EXPANDING AGENCY TERRITORY

New Guidelines are now in effect for both home health and hospice agencies that wish to expand their territory. All requests must be requested in writing to the Bureau. In response to your request you will receive a questionnaire to answer and return to our office. Agencies will then be notified in writing of any approved changes in geographic territory.

- Home Health
 - To add counties, a new agency must be operational for six (6) months following the initial survey before expansion of approved counties will be considered.
 - After approval of expanded geographic territory, further expansion requests will not be considered for a two (2) month period.
 - New territory must be contiguous to existing counties.
 - A request for an addition of a branch will not be considered for at least one (1) year after the initial date of Medicare/State certification.
- Hospice
 - To add counties, a new hospice agency must be operational for six (6) months following the initial survey before expansion of approved counties will be considered.
 - After approval of expanded geographic territory, further expansion requests will not be considered for a two (2) month period.
 - A request for an addition of a satellite will not be considered for at least one (1) year after the initial date of Medicare/State certification.
 - Satellite offices can be no further than 100 miles from the parent office.

CHANGE OF LOCATION

Any home health, hospice, OPT, or CORF agency planning on moving their location must have prior approval by CMS. The agency must submit the request in writing to the Bureau of Home Care & Rehabilitative Standards. It will then be forwarded to Regional Office for final approval.

CHANGE OF OWNERSHIP

This is a reminder to all home health and hospice agencies regarding the process of *Change of Ownership*. The Bureau only processes the requests as they come in. The requests are then forwarded to the Centers for Medicare and Medicaid Services (CMS) who approves or denies them.

- Home Health – Statute 197.420 requires 90 days prior notice
- Hospice – Statute 197.256 requires 30 days prior notice

DISASTER PREPAREDNESS – WHAT ABOUT THE PATIENTS?

Everyone is aware, a major focus right now in health care is on emergency preparedness. Would your agency be prepared if a disaster should occur?

The Bureau understands that in time of a disaster, patients could be displaced to areas outside of an agency's approved geographic area. An agency would be allowed to temporarily service patients in unapproved geographic areas as long as the agency can reasonably take care of the patient's needs.

The Bureau would like to remind all agencies to plan ahead! Assure that your agency has a disaster plan in place, rehearse it regularly and update it as needed! It's all about being prepared!

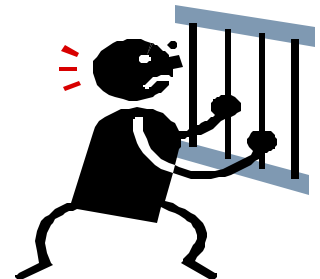
Criminal Disclosure Statement

In the October 2006 Bureau Talk, the Bureau addressed the issue of what an agency would do if they are a hospital-based agency and they hire an employee from the main hospital. We stated, "Laws require that each Medicare provider must run the EDL/criminal background check and if you are a home health agency, check the Family Care Safety Registry (FCSR). A home health agency affiliated with a hospital is its own provider. Therefore, if an employee moves from hospital

employment to home health or hospice employment, the agency will need to re-run the EDL/criminal background check/FCSR."

What we neglected to make clear was that this also **includes the Criminal Disclosure Statement**. Therefore, in order to meet the regulations, if an employee moves from hospital employment to home health or hospice employment, the

agency will also need to have the employee re-sign a new criminal disclosure statement.



HIPAA (Health Insurance Portability & Accountability Act) VIOLATIONS

The issue of a HIPAA violation and how it should be handled was recently brought to the Bureau's attention. After some research and contact with the Office for Civil Rights (OCR), it was found that if anyone thinks there has been a HIPAA violation there is a *Health Information Privacy Complaint* form that needs to be completed by the complainant. Per the OCR, filing a complaint with them is voluntary; however, without the information requested on the form, the OCR may be unable to proceed with the complaint. They collect the information on the form under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996. The OCR will use the information provided on the form to determine

if they have jurisdiction and, if so, how they will process your complaint. Information submitted on the form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with health information privacy compliance and as permitted by law. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing a complaint or for taking any other action to enforce your rights

under the Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, or to obtain an address to send a complaint in writing, go to the OCR web site at: www.hhs.gov/ocr/privacy/hostofile.html.



NURSING DELEGATION

The National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA) have issued a joint statement on delegation. The statement was designed to reinforce that delegation is an essential nursing skill and to support the practicing nurse in using delegation safely and effectively. The "Joint Statement on Delegation" was published in the American Nurses Association *Nursing World*, dated 1/25/07.

This statement can be found at <http://www.nursingworld.org/news/archive/2007/January.htm>.

Although there is considerable variation in the language used to talk about delegation, ANA and NCSBN both defined delegation as the process for a nurse to direct another person to perform nursing tasks and activities. NCSBN describes this as the nurse transferring authority while ANA calls this a transfer of responsibility. Both mean that a registered nurse (RN) can direct another individual to do something that he or she would not normally be allowed to. Both papers stress that the nurse retains accountability for the delegation.

Both the ANA and NCSBN have developed resources to support the nurse in making decisions related to delegation. You can find them in the appendixes on the website. Appendix A of this paper provides the ANA Principles of Delegation. Appendix B presents the NCSBN decision tree on delegation that reflects the four phases of the delegation process articulated by the NCASBN.

GOOD CAUSE WAIVERS/CONDITIONAL EMPLOYMENT

The Bureau has been receiving an increasing number of calls regarding whether or not an employee who has submitted a good cause waiver can be given conditional employment. Some of the calls come from Home Health providers and some are from Hospice Providers. The situation is different depending on what provider type you are.

HOME HEALTH: At this time, home health providers are required to check the EDL, run the Family Care Safety Registry, as well as obtain the Criminal Disclosure Statement on all employees.

- If an employee is on the EDL, they are **not** eligible to apply for a Good Cause waiver.
- If an employee has a “hit” of any type on the Family Care Safety Registry, that employee is prevented from patient contact.
- If the “hit” is one of the criminal history findings specified in section 660.317.6 (crimes against persons), the employee is prevented from patient contact until a Good Cause Waiver is **GRANTED**.

If the “hit” is not one of the above, the employer may hire or retain the individual on a conditional basis once a completed Good Cause Waiver application has been submitted to the Department of Health & Senior Services (DHSS). However, conditional employment must be terminated immediately if the Good Cause Waiver is subsequently closed due to failure to provide requested information or denied.

If the individual has a criminal history finding, to determine whether they are eligible to be considered for conditional employment, the employer must review the criminal history “RAP” sheet, and check the Statute Citation Number (located in the Court Action Date section). A complete listing of disqualifying crimes may be found on the website, <http://www.dhss.mo.gov/goodcausewaiver/CrimesAgainstPersons.html>. If the employee has a “hit” in any of the other areas of the Family Care Safety Registry, the employee may submit a good cause waiver. It will then be up to the agency who is doing the hiring to decide if they will grant conditional employment or not.

HOSPICE: At this time, Hospice providers are required to check the EDL, obtain Missouri Criminal History and obtain the Criminal History Disclosure Statement. Hospices are not required to run the Family Care Safety Registry, although most of them do because it not only captures the required EDL and Criminal History but several other offenses.

- If an employee is on the EDL, the individual is not eligible to apply for a Good Cause Waiver.
- If the “hit” is one of the criminal history findings specified in section 660.317.6 (crimes against persons), the employee is prevented from patient contact until a Good Cause Waiver is **GRANTED**. To determine whether an individual is disqualified, the employer must review the criminal history “RAP” sheet, and check the Statute Citation Number (located in the Court Action Date section). A complete listing of disqualifying crimes may be found on the website, <http://www.dhss.mo.gov/goodcausewaiver/CrimesAgainstPersons.html>.
- Any other findings reported by the FCSR are not considered disqualifications (Sex Offender Registry, Child Abuse/Neglect findings, DMH (Department of Mental Health) Employee Disqualification Registry, Foster Parent or Child Care license revocation).

IT IS ALWAYS THE EMPLOYER’S RESPONSIBILITY TO MAKE THE HIRING DECISION. EVEN IF THE INDIVIDUAL IS GRANTED A GOOD CAUSE WAIVER, THE EMPLOYER IS RESPONSIBLE FOR MAKING THE FINAL DECISION WHETHER TO HIRE THAT INDIVIDUAL OR NOT.

HOME HEALTH SURVEY SCHEDULE

As with FY 2006 the Centers for Medicare & Medicaid Services, (CMS) has again developed the Survey Mission & Priority Document for FY 2007. This document assists the states in determining how many Medicare surveys they need to complete for this fiscal year. This will give the states guidelines to assist in prioritizing their workload.

As was with last fiscal year, there are four tiers for home health (HHA) surveys for FY 2007.

Tier 1 (27 agencies), consist of a list of HHAs that have been identified by CMS; the highest priority rating; assures HHAs are surveyed at least every 36 months.

Tier 2 (13 agencies); consist of a list of HHAs that have been identified by CMS that are at greatest risk for failing to provide quality care.

Tier 3, has no criteria

Tier 4 (43 agencies), additional surveys based upon the state's determination of agencies most at risk of providing poor care; ensures that ultimately 50% of all HHAs are surveyed each year.

MISSOURI IN COMPARISON WITH OTHER STATES

The Bureau recently received information from Regional Office in Kansas City regarding how the four (4) States in Region VII compares with other states in the nation on survey action. The first comparison was in the top ten (10) home health tags cited in the nation. The Bureau was pleased to see that Missouri surveyors hit seven (7) of

the top ten (10) tags cited in fiscal year 2006. The top two (2) home health tags cited in the nation for fiscal year 2006 were G158 and G236, both of which were the top two (2) home health tags cited by the Missouri surveyors!



HOME HEALTH COMPARE

One of the focuses of the Missouri Governor is to promote healthcare in the industry world. As a Bureau of the Department of Health & Senior Services, Home Care and Rehabilitative Standards, has been asked by the Governor what it is that we do to promote health care in the industry world. One of the things that the Bureau

has always promoted and will continue to promote is the Home Health Compare website. As you all are aware, the website is www.medicare.gov/HHCompare. If a patient or family member calls and wants to know any information about a home health agency, we will refer them to this website. A link to this website will also be

added to our Bureau website www.dhss.mo.gov/HomeCare.

GENERAL ISSUES

• HOME HEALTH

- If a patient meets all of his/her goals and is discharged from home health, an interim order would **not** be required. However, a surveyor would expect to see some type of communication to the physician. Also, the surveyor would refer to the agency's policy in these types of situations and the agency would be expected to have followed their policy.
- M0072 Primary Referring Physician ID Entries - Beginning May 23, 2007, Home Health Agencies (HHA) must begin entering the physician's NPI number in OASIS item M0072 - Primary Referring Physician ID. To accomplish this, HHAs should begin gathering NPI numbers from physicians to be entered into OASIS Item M0072 for any assessment completed on or after May 23, 2007. Agencies should also begin working with their software vendors to determine if any changes are required to accommodate this. The OASIS Data Specifications Version 1.50 and Haven 7.1 currently provide 10 spaces for this OASIS item. This space is sufficient to accommodate the Physician's NPI number.
- Tag G238 - This tag states, "If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient". Agencies need to remember that some type of transfer form or summary must be provided by the agency when a patient is transferred to another health facility.
- Services and frequencies ordered by the physician must be given to the patient in writing upon admission.
- Agencies cannot waive a patient's co-pay before they provide services. According to CMS, this is seen as an enticement or inducement.
- Of the 50 states only 14 have more home health agencies than Missouri!

• HOSPICE

- Per discussion with CMS Regional Office and/or CMS Central Office
 - If a patient does not have a Do Not Resuscitate (DNR) order, this does not preclude the patient from being admitted to hospice. Based on law and regulation, Medicare certified hospice providers may not refuse to have staff skilled in resuscitation or refuse to revive a patient who desires to be resuscitated. However, the hospice may counsel patients at election as to the hospice's philosophy on this issue and patients whose views are at odds with the hospice philosophy may elect to receive care from another source.
 - Agencies with satellite locations can have the same IDG team as long as they function per the federal hospice regulations. Regional Office response was: "We expect hospices to have policies and procedures in place that are in agreement with the IDG requirements at 42 CFR 418.68 and we expect that they adhere to these requirements if they wish to remain in the Medicare program. The hospice regulations require an interdisciplinary approach to the provisions of care & services. The IDG should not function in a multidisciplinary format where each discipline simply makes decisions for necessary care within a particular discipline. The IDG should function in an interdisciplinary format where each discipline gives input from the viewpoint of the discipline for all issues facing the patient."

HOSPICE CONTINUED

- Regarding Hospice Tag L116, 42 CFR 418.56(a), a surveyor cannot cite an agency if there is not documentation in the medical record at the hospice stating that the coordinated plan of care was placed in the nursing home record. Based on response from CMS Central Office, there is nothing in the regulations that states the agency has to specifically note in the chart that the plan of care was placed in the SNF record. But, if the surveyor has doubts about there being a coordinated plan of care and there is poor patient outcomes, the surveyor will further investigate and if there is an issue will then cite under another tag.
- Implementation of the plan of care changes resulting from physician orders received by the nursing facility must have prior hospice approval.
- It is imperative that all hospice agencies have back-up personnel for their core services. Per Regional Office, if a hospice agency loses a core service the agency cannot operate. When this occurs in an agency the hospice needs to notify Lisa Coots, Bureau Administrator. A 1-2 week grace period may be granted by the administrator (depending on the discipline) to allow the agency to re-hire whatever core service they have lost. If it is the medical director position that is vacant, the hospice will not be given a grace period and the hospice cannot operate at all. The Bureau expects that the hospice agency notify us immediately of a vacancy and it will be reviewed on a case-by-case basis.
- Please review CFR 418.28: an individual or representative may revoke the individual's election of hospice care at any time during an election period. To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

- (1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period.
- (2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made).

An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period –

- (1) Is no longer covered under Medicare for hospice care;
- (2) Resumes Medicare coverage of the benefits waived under 418.24 (e)(2); and
- (3) May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

- Comfort Packs - The hospice surveyors have recently updated the comfort pack information cheat sheet. You can find this updated information on the Home Care web site @www.dhss.mo.gov/HomeCare. To view click on *Publications, October 2006, Attachment 4*.
- Standing orders: Remember, standing orders are not to consist of "ranges" in the order.

HOSPICE CONTINUED

- *Home Health & Hospice Medicare A Newslines*, dated March 1, 2007, recently addressed the following question:

Q: At times, when a beneficiary's Power of Attorney (POA) lives out of state, and time-sensitive correspondence, such as election statements, must be issued to the POA. Will agencies be able to use the date that they spoke to the POA as the hospice election date or should they use the actual date the document was signed? Do the same rules apply to the Advance Beneficiary Notice (ABN) and Expedited Determination (ED) Notice?

A: Medicare does not recognize verbal hospice elections. Therefore, the date used on the hospice election must be the date on the signed election statement. For example, the hospice spoke with the Power of Attorney (POA) on January 11, but the hospice election statement was actually signed and dated on January 15. In this example, the election would be effective January 15; the date it was signed/dated. To eliminate delays, a faxed form would be acceptable.

The ABN, according to the Medicare Claims Processing Manual, (CMS Pub 100-04), Ch 30 40.3.4, should be hand-delivered to the beneficiary or authorized representative. However, if hand-delivery is impossible, the ABN can be delivered by mail or fax. However, CAHABA GBA, LLC, cannot consider a telephone notice to be sufficient evidence unless the content of the telephone contact can be verified and is not disputed by the beneficiary.

The ED Notice instructions state if the provider is unable to personally deliver a notice, they should telephone the beneficiary or their representative to advise when the beneficiary's services are no longer covered. The date of the conversation is the date the notice is received. A written notice mailed on that same date must confirm the telephone contact. A dated copy of the notice must be kept in the beneficiary's medical file and the telephone call must be documented including the name of person initiating the contact, name of the representative contacted, date and time of the contact and the telephone number called.

- Of the 50 states, only 9 have more hospice agencies than Missouri!

HOSPICE SURVEY SCHEDULE

◆ STATE

- ◆ The Bureau's goal is to conduct a state survey at least every 2 years.

◆ FEDERAL

- ◆ As with home health, the Survey Mission & Priority Document for FY 2007 assists the states in determining how many Medicare surveys they need to complete for this fiscal year. This gives the states guidelines to assist in prioritizing their workload. There are three (3) Tiers for hospice surveys.

TIER 2 (5 agencies) - 5 % of the hospices in the state are surveyed based on those most at risk of quality issues.

TIER 3 (0 agencies) - Additional surveys are done, based on state judgment regarding agencies most at risk of quality problems. This assures all hospices are surveyed, on average, every 10 years.

TIER 4 (10 agencies) - Additional surveys are done (beyond Tiers 2 & 3) such that all providers are surveyed, on average, every six (6) years.

National Home Health Campaign Targets Acute Care Hospitalization

The Centers for Medicare and Medicaid Services (CMS) has launched a national home health quality improvement campaign to reduce avoidable hospitalization. Primaris, as Missouri's Quality Improvement Organization (QIO) is leading the initiative and working with the Missouri Alliance for Home Care (MAHC) and the Missouri Department of Health and Senior Services (Bureau of Home Care & Rehabilitative Standards) to encourage all of Missouri's Medicare-Certified home health agencies to participate.

The Bureau felt that "Bureau Talk" was a good opportunity for Primaris to share some of their valuable information with you.

Following is information that was prepared by Primaris, under contract with CMS. The contents presented do not necessarily reflect CMS policy.

Are you satisfied with your current ACH outcome rate? Is it as good as you can get? If so, can you sustain that rate over the next months? Years?

The campaign offers a unique opportunity for you to join the almost 5,000 home health agencies nationwide currently participating to optimize your agency's performance with support, resources, and new benchmarking based on CMS data. By joining the campaign today your agency can begin receiving the following:

- ◆ A free monthly ACH Best Practice Implementation Package (BPIP). Each month's packet provides tools and resources focused on a different strategy or best practice to reduce avoidable hospitalizations. Some resources are appropriate for those who have already begun implementation of that strategy; others for those just starting out.
- ◆ Free training for your staff. Training resources are provided that focus on how to implement the best practice strategy with patients. Free CEUs are available for licensed nurses. Modules for home health aide in-service training and training for therapists and social workers are included.
- ◆ Monthly performance reports. Participating agencies receive a new monthly report with actual and risk-adjusted ACH rates, as well as information about your hospitalizations (reason, emergent/elective and day of the week). National and statewide benchmarking based on CMS data is included.
- ◆ A "seal of recognition" HHQI logo. Show your patients and referral sources that you are committed to providing high quality care that allows your patients to be appropriately managed in the home environment.

There is no cost to join and no additional data collection required, since only currently collected OASIS data is used. **So why haven't you joined?** Simply follow these steps to register, and in less than 5 minutes you can start downloading your free resources.

1. Visit www.homehealthquality.org
2. Click on "Home Health Agency Registration"
3. Fill out the form on the Web site— you will need your six digit Medicare provider number when you register
4. Click "Submit"

If you have any questions about the HHQI National Campaign, contact your Primaris home health regional manager for assistance:

For eastern Missouri: Teresa Northcutt RN BSN
1-800-735-6776, Ext. 145; tnorthcutt@primaris.org

For western Missouri: Sandy Morgan RN
(816) 651-3450; smorgan@primaris.org

News from the MOO arena...



By Joyce Rackers, R.N.

As usual, things continue to be busy in the MOO arena! OASIS training sessions are offered twice a month at the Jefferson City office and they continue to be full to capacity! I am now taking reservations for July 2007. If you are interested in signing up any of your nurses or therapists, just give our office a call at 573/51-6336.

As you all are aware, OASIS is forever evolving. Over the last six (6) months of training I have received questions and scenarios from agencies that I have referred to CMS for guidance in answering. In the process, I have also received new guidance on some older OASIS issues. In Attachment A of this Bureau Talk you will find numerous questions and answers (Q & A's) regarding issues that I have received clarification on from CMS in the past few months.

With Pay for Performance coming, it is **imperative** that clinicians across the board are consistent in answering the OASIS items. Please make sure the nurses and therapists in your agency have access to these Q & A's. Some of these Q & A's address scenarios that have been discussed in some of my earlier trainings but CMS has now taken a different approach on how to interpret them. This is my only way of getting the new information out to your clinicians, so please share the attachment with them.